Well-Ahead Louisiana Primary Care Office

State Loan Repayment Program

# Site Information Form OFFICE USE ONLY

Completed by the employer and must include one (1) year of data Date Rec’d: \_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- |
| Name and Address of Practice Site:  Click to enter text. | | | Name and Address of Employer (if different):  Click to enter text. | |
| Employer Contact Name and Title: Click to enter text.  Employer Contact E-mail: Click to enter text.  Employer Contact Telephone: Click to enter text.  Employer Contact Fax: Click to enter text. | | | Telephone Number at Practice Site: Click to enter text.  Fax Number at Practice Site: Click to enter text.  Employer’s telephone: Click to enter text.  Employer’s fax: Click to enter text. | |
| Type of Practice:  Public  Non-profit  Both  (provide proof of checked practice type with application)  Type of Facility:  FQHC  RHC  Private  State  Other Click to enter text. | | | Employer’s Medicaid ID#: Click to enter text.  Employer’s Medicare ID#: Click to enter text. | |
| Provide a brief description of the SLRP Clinician’s duties to include, patient load, hospital privileges, and explanation of any special work related responsibilities for the position.  Click to enter text. | | | | |
| What is the SLRP Clinician’s routine work schedule? Include office hours, call coverage, etc.  Click to enter text. | | | | |
| How many patients were seen at this location last year?  Click to enter text. | | | How many of these patients were uninsured?  Click to enter text. | |
| How many of these patients were in Medicaid managed health plans? Click to enter text. | | | How many of these patients were Medicare?  Click to enter text. | |
| How many of these patients are from targeted populations who are designated as underserved in your service area? | | | | |
| Underserved Population | Estimated % of Patients | | | Does this facility agree to continue to serve this population? |
| Migrant Farm Workers | Click to enter text. | | | Yes  No |
| Homeless | Click to enter text. | | | Yes  No |
| HIV Positive | Click to enter text. | | | Yes  No |
| LGBTQ+ | Click to enter text. | | | Yes  No |
| Persons with SUD | Click to enter text. | | | Yes  No |
| Other Click to enter text. | Click to enter text. | | | Yes  No |
| Does this practice site currently have in place a sliding fee scale/indigent care policy for patients at or below 200% of the Federal poverty level?  Yes  No If yes, what percentage of uninsured patients was eligible for reduced fees last year? When was the policy established? Click to enter a date. When was the policy last updated? Click to enter a date.  Are signs posted to inform patients of this policy?  Yes  No (provide examples of signage/notices in place) | | | | |
| Besides posted signs, how does the site ensure that patients are aware of the availability of the sliding fee scale/indigent care policy? Please give details and samples if applicable. Click to enter text. | | | | |
| NOTE: The applicant will be notified of the decision whether or not to support this request by the end of September. The clinician’s contract for SLRP will not begin until October 1, 2021 if the clinician is awarded funds. | | | | |
| Employer Signature: | | Date Application Mailed: | | |